REQUEST FOR CATASTROPHIC LEAVE

To: _____ Date: _____
(Supervisor)

From: _____(_____) Department: _____
(Employee) (Employee ID)

Please indicate below the purpose for which you are applying for Catastrophic Leave:

_____ My physician has advised me that I will be unable to return to work for an indefinite, extended period due to a non-job related, seriously incapacitating illness or injury, **OR**

_____ The Health Care Provider for my spouse / child / parent / domestic partner has advised me that I am needed to provide physical and/or psychological care for them because of their inability to do so.

Name of Family Member and relationship to employee: _____

Description of medical condition of self or family member (facts which support this request):

_____

_____

_____

_____

Approximate date condition commenced: _____

Probable duration of condition: _____

I will exhaust my paid leave balance, including medical leave, vacation, and compensatory time, on _____. I will become eligible for LTD on _____.

I, therefore, request consideration under the provisions of the City of Tempe Catastrophic Leave Policy.

Employee Signature: _____ Date: _____

Attending Physician: _____ Date: _____

Physician's Phone: _____

Supervisor's Signature: _____ Date: _____

Supervisor: Please forward form to Human Resources.

HR Use Only

Date Received: _____